Guideline

Medicare Billing for Privately Referred Non-Inpatient Services in NSW Public Hospitals

Summary The purpose of this Guideline is to provide a framework within which participating medical practitioners and Local Health Districts / Specialty Health Networks must operate to ensure Medicare compliant billing.

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Secretary, NSW Health

MEDICARE BILLING FOR PRIVATELY REFERRED NON-INPATIENT SERVICES IN NSW PUBLIC HOSPITALS

GUIDELINE SUMMARY

The purpose of this Guideline is to provide a framework within which participating medical practitioners and Local health Districts (Districts)/Speciality Health Networks (Networks) must operate to ensure Medicare compliant billing in outpatient departments.

This Guideline is to provide information for all participating medical practitioners and Districts /Networks to ensure the operation of Medicare compliant billing.

Medical practitioners are granted rights of private practice (RoPP) for privately referred non-inpatient services as a condition of their appointment with NSW Health, or part of an overall arrangement. This would be limited to staff specialists, clinical academics, visiting medical officers and honorary medical officers. It also pertains to all District/Network administrative staff involved in billing on the medical practitioner's behalf.

KEY PRINCIPLES

The key principles of this Guideline are:

- Every patient must be given the choice to be treated as a public or a private patient
- Where a patient chooses to be treated as a public patient all components of the public hospital service (such as pathology and diagnostic imaging) will be regarded as part of the patient's treatment and will be provided free of charge
- Public patients must be provided with the same services as private patients
- Where a patient chooses to be treated as a private patient, they must have a referral to the named medical practitioner exercising RoPP
- All medical practitioners must have RoPP before billing Medicare/patient
- Referrals must be valid as stipulated by Medicare, Commonwealth Department of Health, National Health Reform Agreement (2011) and Addendums and the Staff Specialist Determination 2015 if a medical practitioner is to bill Medicare in NSW
- Referral pathways must not be controlled so as to deny access to free public hospital services
- Named referrals must not be a prerequisite for access to outpatient services
- Referrals cannot be shared
- Personal performance is required for all referred consultation services when billing Medicare
- Every patient is entitled to informed financial consent

USE OF THE GUIDELINE

Districts and Networks are to use this Guideline to ensure Medicare compliant billing and equity of access, while respecting the right of the patient to make a choice.

The intent of the Guideline is to ensure that privately referred non-inpatient services billed to Medicare are fully compliant with all legislative/government requirements.

REVISION HISTORY

Version	Approved by	Amendment notes
March-2021 (GL2021_005)	Dep Secretary, Financial Services and Asset Management	Initial Document

ATTACHMENTS

1 Medicare Billing for Privately Referred Non-Inpatient Services in NSW Public Hospitals: Guidelines

CONTENTS

1 BACKGROUND

This document provides guidance for NSW Health medical practitioners and Local Health Districts (Districts) and Speciality Health Networks (Networks) administrative staff when billing for privately referred non-inpatient services in NSW public hospitals. All sections of this document are to be read by medical practitioners and those billing on their behalf.

Information in this document can be found in the:

- Health Insurance Act 1973 (The Act)
- Health Insurance Regulations 2018; and associated tables (General Medical, Diagnostic Imaging and Pathology Services)
- Medicare Benefits Schedule (MBS)
- National Health Reform Agreement 2011 (NHRA) and the 2020-2025 Addendum

And on the:

- Department of Health and Services Australia websites
- NSW Health website

This Guideline is not exhaustive and medical practitioners are to continue to liaise with Services Australia's Medicare program.

Under the NHRA, NSW is committed to the following Medicare Principles:

- Eligible persons must be given the choice to receive public hospital services free of charge as public patients;
- Access to services is based on clinical need and within clinically appropriate timeframes;
- Equity of access is for all eligible persons regardless of geographical location.

Free of charge means **no charges** should be raised against the patient or Medicare.

Schedule G (Business Rules) in the NHRA permits the billing of private outpatient services in public hospitals provided the following conditions are met:

- patients must be given the choice to be treated as public or private and this choice must be recorded;
- public patients must be provided with the same access to services as private patients;
- where a patient chooses to be treated as a private patient, they must have been referred to a named medical specialist who is exercising RoPP;
- the patient must be informed of any financial obligations (informed financial consent).
- Districts/Networks must ensure that referral pathways are not controlled to deny access to free public hospital services or so that a referral to a named specialist is a prerequisite for access to outpatient services.

1.1 Key definitions

Eligible person

An Australian resident or an eligible overseas representative (as defined in the *Health Insurance Act 1973*), excluding compensable patients.

DOH

Commonwealth Department of Health.

MBS

Medicare Benefits Schedule.

Medical practitioners

Staff Specialists, Clinical Academics, Honorary Medical Officers and Visiting Medical Officers (VMOs).

NHRA

National Health Reform Agreement 2011 and Addendums.

RoPP

Rights of private practice granted to medical practitioners working in NSW public hospitals as a condition of their employment or part of an overall arrangement.

1.2 Legal and legislative framework

The legislation governing the MBS is the *Health Insurance Act 1973* (the Act). The *Health Insurance Regulations 2018* are made under the Act and define practices that are acceptable. For a full list of the major acts, regulations and determinations please refer to MBS Online.

2 BILLING MEDICARE FOR SERVICES PROVIDED IN AN OUTPATIENT SETTING

2.1 Funding mechanisms

Public hospitals are hospitals that are government-funded through both Commonwealth and State/Territory payments. This funding is underpinned by the NHRA. NSW has signed the 2020-2025 Addendum to the NHRA, as such NSW Health is obliged to adhere to all Schedules. This means that additional criteria must be met if outpatient Medicare billing is to occur.

2.2 District/Network responsibilities

Districts/Networks may bill Medicare for services rendered by medical practitioners. Districts/Networks must ensure that MBS item numbers billed have been approved by the treating medical practitioner. In addition, the District/Network must provide visibility to the medical practitioner of all billing occurring under the medical practitioner's Medicare provider number.

Administrative staff working in outpatient services are expected to follow this guideline.

2.3 Medical Practitioner Responsibilities

Medical practitioners granted rights of private practice (RoPP) for privately referred non-inpatient services as a condition of their appointment with NSW Health, or part of an overall arrangement, are expected to follow this Guideline. This is limited to staff specialists, clinical academics, visiting medical officers and honorary medical officers (medical practitioners).

Overseas trained doctors who have an s19(AB) exemption (subject to any conditions) may also bill Medicare if they have a RoPP in place.

Each medical practitioner granted RoPP has a legal responsibility to comply at all times with the applicable provisions of the Act, the Commonwealth's Medicare Benefits Schedule (MBS) the NHRA business rules and other relevant information as specified by the DOH and Services Australia (formerly the Department of Human Services) that apply to patient billing.

2.4 NSW Health requirements when exercising RoPP

Medical practitioners when exercising RoPP must comply with applicable NSW Health policy directives and guidelines, contract terms and industrial instruments, including but not limited to (as varied from time to time):

- Staff Specialists – the *Staff Specialists Determination 2015* and NSW Health Policy Directive *Staff Specialist Rights of Private Practice Arrangements* (PD2017_002)
- Visiting Medical Officers – NSW Health Guideline *Standardised Licence Arrangements for VMOs Providing Private Non Admitted Services* (GL2009_008).
- Clinical Academics – NSW Health Policy Directive *Clinical Academics Employed in the NSW Health Service* (PD2019_055).

2.5 The importance of Medicare Provider Numbers (MPNs)

2.5.1 Applying for provider numbers

Applying for MPNs will be the responsibility of the eligible medical practitioner. Health professionals who are registered with the Australian Health Practitioner Regulation Agency (AHPRA) or an approved registration body can apply for a provider number.

2.5.2 What is a provider number and what does it do?

A provider number is a unique number that is issued to eligible health professionals who apply to participate in the Medicare Program. Some Medicare provider numbers can only be used to refer or request services.

A provider number cannot be used arbitrarily because it identifies a particular health professional's eligibility to access Medicare benefits, their eligibility to refer or request services that attract Medicare benefits and the practitioner's qualifications, registration and any restrictions to accessing Medicare benefits.

2.5.3 Provider numbers and Medicare

A medical practitioner must have an MPN before they can bill, refer or request services that attract a Medicare benefit. If a medical practitioner practices at more than one location, changes locations or is registered in multiple health professions, additional provider numbers will be required.

Medical practitioners **cannot** use another medical practitioner's provider number under any circumstances.

Districts/Networks **cannot** commence making claims on behalf of a medical practitioner employed or contracted to the District/Network without written authorisation.

For further information regarding registration/applying for Medicare provider numbers, participating medical practitioners should contact:

Medicare Provider Enquiries:

Phone: 132 150

Email: medicare.prov@servicesaustralia.gov.au

2.6 Billing Medicare

2.6.1 Minimum requirements

The minimum requirements for billing Medicare are listed below:

- the patient must have chosen to be treated as a private patient, been informed of any potential costs and be eligible for a Medicare benefit;
- a medical practitioner's appointment with the health service must provide that the practitioner is permitted to exercise RoPP;
- the medical practitioner must have a valid provider number for each location at which private outpatient services are provided and subsequently billed;
- the medical practitioner must have received a valid referral prior to the attendance/procedure;
- the attendance/procedure must be personally performed (unless otherwise stated in the MBS);
- the MBS item number must be correctly billed for the service provided;
- the service performed must be eligible under Medicare and not funded by other Government means or a third party (e.g. Motor Accident, Workers Compensation); and
- the attendance/procedure must be documented and/or reported in the patient's medical record. It must include the signature of the practitioner who personally performed the service.

Current inpatients cannot be billed to Medicare when attending an outpatient clinic.

The assigning of an MBS item number to a service is the responsibility of the treating medical practitioner because the medical practitioner is the only person who can confirm

that all the service requirements of the item descriptor have been met. Administrative staff do not know if this has occurred when a service is provided.

2.6.2 Assignment of benefits

In accordance with section 20A of the Act, an approved assignment form must be completed and signed by the patient or other responsible person.

Services Australia's webpage states that:

"The legislative requirements for the assignment of benefits are:

- an agreement must be made between the patient (assignor) and the medical practitioner for the assignment of benefit;
- the agreement is "evidenced" using the assignment of benefit form;
- the patient is required to sign the form;
- a copy of the agreement must be provided to the patient".

The patient or other responsible person must not sign a blank or incomplete assignment of benefit form. The form must be printed, provided to the patient to review, sign and given to retain for their records.

If using an online system, the recording of assignment of benefits is still required, but in an electronic format that meets all Medicare requirements.

2.6.3 Signature by a third party

If the patient cannot assign their right to a Medicare benefit for manual and online claiming, Medicare can accept a signature on the assignment form from a third party – for example, the patient's:

- parent
- guardian
- power of attorney
- other responsible person.

The practitioner must:

- note in the **Patient Signature** field that the patient is **unable to sign**;
- note in the **Provider Use** field, why the patient is unable to sign – for example injured hand;
- initial or sign their notes.

2.6.4 Substantiating a claim

Providers are no longer required to retain a copy of the assignment of benefit form. However, Medicare can still request the medical practitioner to substantiate a claim. Documents to substantiate a claim include:

- a copy of the referral;
- evidence that the patient chose to be treated as a private patient;

- an extract from the clinical records showing that the medical practitioner personally rendered the service;
- a copy or extract of a document that verifies authorisation to exercise RoPP in a public hospital including outpatient services.

3 VALID REFERRALS FOR MEDICARE BILLING IN PUBLIC OUTPATIENT DEPARTMENTS

3.1 Valid referrals

For a referral to be valid:

- The referring practitioner must have undertaken a professional attendance with the patient and turned his or her mind to the patient's need for referral and have communicated relevant information about the patient to the specialist or consultant physician (this need not mean an attendance on the occasion of the referral);
- It must be written by a health professional who is registered with a national board (for example the Medical Board of Australia), has an AHPRA number (or equivalent) and has a provider number with Medicare Australia;
- It must be written by a medical practitioner in private practice (including medical practitioners exercising RoPP in a public facility);
- It is to be addressed to a clinician (exercising RoPP) by name. It cannot be addressed to an outpatient department, hospital, clinic or a Junior Medical Officer (JMO);
- It must be signed and dated by the referring practitioner and include the provider number or practice address of the referring practitioner;
- It is to state the period of referral (when other than 12 months) expressed in months e.g. "3", "6" or "18" months or "indefinitely";
- It must be received on or prior to the occasion of the professional service.

A referral that does not state a time for which it remains valid is only valid for 12 months **after the first service rendered** in accordance with the referral. This **does not** include specialists or consultant physicians where the period of referral is for a maximum of **3 months after the first service given** in accordance with that referral.

If a referral fails to meet all legislative, Commonwealth and State requirements, the referred patient cannot be treated as a privately referred non-inpatient. If a patient wants to be a private patient in the absence of a valid referral, the patient can request a new valid referral from their referring practitioner.

3.2 General Practitioner (GP)

The GP is regarded as the primary source of referrals, as such it is expected that the patient's GP will be kept informed of the patient's progress. The GP's referral is usually valid for 12 months (unless otherwise stated).

3.3 Specialist Referrals

A referral from a specialist or a consultant physician must include the name of the patient's general practitioner or practice, participating midwife or participating nurse practitioner nominated by the patient. Where a patient is unable or unwilling to name a general practitioner or practice this must be stated in the referral.

Cross-referrals between specialists and/or consultant physicians should usually occur in consultation with the patient's general practitioner.

Where a referral originates from a specialist or a consultant physician, the referral is valid for **3 months** from the **date of service**.

3.4 Single course of treatment – New patients – MBS Excerpts

A single course of treatment is defined by the MBS as "an initial attendance by a specialist or consultant physician and the continuing management/treatment up to the stage where the patient is referred back to the care of the referring practitioner." This includes all subsequent attendances/reviews regardless of location.

3.5 Single course of treatment – Existing patients – MBS Excerpts

The receipt by a specialist or consultant physician of a new referral following the expiration of a previous referral for the same condition(s) does not necessarily indicate the commencement of a new course of treatment involving the itemisation of an initial consultation. In this situation the new referral is to facilitate the payment of benefits at the referred rates rather than the unreferred rates.

The exception to this occurs when the referring practitioner:

- deems it necessary for the patient's condition to be reviewed; and
- the patient is seen by the specialist or the consultant physician outside the currency of the last referral; and
- the patient was last seen by the specialist or consultant physician more than 9 months earlier;

then the attendance following the new referral initiates a new course of treatment for which a Medicare benefit would be payable at the initial consultation rates.

The presentation of an unrelated illness, requiring the referral of the patient to the specialist's or the consultant physician's care would initiate a new course of treatment in which case a new referral would be required.

3.6 Referral Exceptions – MBS

A referral for pre-anaesthesia consultations (items 17610 - 17625) is not required. Similarly if a referral has been made but the letter or note of referral has been lost, stolen or destroyed, benefits will be payable at the referred rate if the account, receipt or the assignment form shows the name of the referring medical practitioner, the practice address or provider number of the referring practitioner (if known) and the words "Lost referral". This provision applies to one attendance.

3.7 Referrals that cannot be used for Medicare billing in public outpatient departments

The following referrals **cannot** be used for Medicare billing:

- referrals generated in an emergency department to an outpatient department to receive services from a medical practitioner exercising RoPP;
- referrals to an outpatient clinic or hospital (i.e. not to a named physician);
- referrals written by an intern, resident medical officer, career medical officer, registrar or medical superintendent; and
- referrals to oneself.

3.8 Emergency Departments/Services

Emergency department patients **cannot** be referred to an outpatient department to receive services from a medical practitioner exercising RoPP under the terms of employment or a contract with a hospital which provides public hospital services. Any requests for diagnostic imaging and pathology services ordered while an eligible patient is in the emergency department (prior to admission) cannot be billed to Medicare.

3.9 Discharge Summaries/Referrals are not valid referrals

It is expected that patients on discharge should have discharge summaries/referrals sent to their general practitioner, where recommendations can be made for the appropriate management of the services the patient may require. The discharge summary should also state whether the patient was admitted as public or private.

A hospital discharge summary is not designed to be a valid referral and it would not necessarily meet the appropriate requirements for a valid referral. Discharge summary documents support the transfer of a patient from a hospital back to the care of their nominated primary healthcare provider.

3.10 Inappropriate practices

If a follow-up after discharge is a necessary component of the service and is at the recommendation of the practitioner working in the public hospital, the follow-up treatment can be considered an intrinsic part of the public hospital episode of care and is not expected to be billed to the MBS. Therefore, a patient should not be sent to a GP merely for a referral to a named specialist.

The same referral cannot be shared by multiple medical practitioners when billing Medicare.

“Figurehead billing” that is, billing Medicare using a single provider’s name/provider number for services not rendered by or on behalf of that medical practitioner is not permitted.

Districts/Networks must ensure that referral pathways are not controlled so as to deny access to free public hospital services. Referral pathways must not be controlled so that a referral to a named specialist is a prerequisite for access to outpatient services.

4 REQUEST FORMS

4.1 Request Forms – General Information

Requests forms are not "referrals". A named request is not required for billing services to Medicare. Please refer to the AskMBS Advisory *"Non-GP specialist and consultant physician services"* August 2020 for further information.

Under the Act and associated regulations, medical practitioners (and other prescribed practitioners) can request pathology and diagnostic imaging services for the purpose of the payment of Medicare benefits for private patients subject to any other requirements as to the type of service they can request. There is no requirement in the Act for the requesting medical practitioner to be also eligible to access Medicare benefits for services they provide. However, under the Staff Specialist Determination, a medical practitioner must be able to exercise RoPP when requesting a service for it to be eligible for a Medicare benefit.

NSW Pathology, NSW public hospital diagnostic imaging departments and other pathology/diagnostic imaging providers engaged by Districts/Networks must meet both the requirements of Commonwealth legislation and the NHRA in order to bill Medicare for services rendered at or on behalf of a NSW public hospital.

Where a patient chooses to be treated as a public patient, components of the public hospital service (such as pathology and diagnostic imaging) will be regarded as part of the patient's treatment and will be provided free of charge. As a result, diagnostic imaging and pathology service providers should check the patient's status before billing Medicare.

Any patient who presents to an Emergency Department and is given a request form for a diagnostic imaging or pathology service at the hospital's outpatient clinic, that service cannot be billed to Medicare.

4.2 Diagnostic Imaging Services – Requests for R-type Diagnostic Imaging

Responsibility for the adequacy of requesting details rests with the requesting practitioner. Although there is no set format, legislation provides that a request must be in writing and contain sufficient information in terms that are generally understood by the profession, to clearly identify the item/s of service requested.

The Electronic Transactions Act 1999 allows for documents required by law to be in writing, to instead be provided electronically. Diagnostic imaging requests may be made by email or other electronic medium, either directly to the imaging practice (with the patient's consent) or via the patient as long as:

- the recipient agrees to the request being made in that form;
- it would be accessible for subsequent reference; and
- it contains the information prescribed as for requests made in writing.

A written request must be dated and contain the name and address or name and provider number in respect of the place of practice of the requesting practitioner. This is to facilitate Medicare billing.

The form must include a statement that informs the patient that the request may be taken to a diagnostic imaging provider of the patient's choice.

The following practitioners can request a diagnostic imaging service:

- specialists and consultant physicians can request any diagnostic imaging service
- other medical practitioners can request any service and specific MRI services (refer to MBS)
- medical practitioners on behalf of treating practitioners

This does not mean that every request is rebateable under Medicare. The requesting practitioner must be exercising RoPP if they work in a public hospital for the test to be billed to Medicare.

4.2.1 Exemptions for R-type diagnostic imaging services – MBS

Self-determined "additional tests"

A written request is not required for the payment of Medicare benefits when the diagnostic imaging service is provided by or on behalf of a consultant physician or a specialist (other than a specialist in diagnostic radiology) who, after clinical assessment determines that the service was necessary. This is a self-determined service.

If the referral specifically requests a test, the service provided is not self-determined. If further services are subsequently provided, these services are self-determined (as additional services). Requests are not required for these self-determined "additional tests".

Note that the following services cannot be self-determined as "additional services"

- MRI services
- PET services; and
- services not otherwise able to be requested by the original requesting practitioner.

Remote areas

A written request is not required for the payment of Medicare benefits for an R-type diagnostic imaging service rendered by a medical practitioner in a remote area. However, the following rules must be adhered to:

- The R-type service is not one where there is a corresponding NR-type service; and
- The medical practitioner rendering the service has been granted a remote area exemption for that service.

Emergencies

A written request is not required if the providing practitioner determines that, because the need for the service arose in an emergency, the service should be performed as quickly as possible.

4.3 Pathology Services

Under the Health Insurance Regulations 2018, a request for a pathology service must include the following information in relation to the treating practitioner or approved pathology practitioner who makes the request (the requesting practitioner):

- the name of the requesting practitioner
- if the request was made at a place of practice of the requesting practitioner:
    - the address of the place of practice; or
    - if the requesting practitioner has been allocated a provider number in respect of the place of practice – the provider number
- if the request was not made at such a place of practice:
    - the address of any place of practice of the requesting practitioner; or
    - the provider number of the requesting practitioner in respect of any place of practice;
- the date on which the treating practitioner determined that the service was necessary.

Information about the patient – *Part 3, Division 2, Section 34 of the Health Insurance Regulations 2018* (use link provided and go to "latest version" if required) can be found here.

This does not mean that every request is rebateable under Medicare. The requesting practitioner must be able to exercise RoPP if they work in a public hospital for the requested test to be charged to Medicare.

The form must include a statement that informs a person that the request may be taken to a pathology provider of the person's choice.

Pathology request forms must also comply with the MBS *Responsibilities of Approved Pathology Practitioners,* which outlines the minimum details that pre-printed forms and combined pathology request/offer to assign forms must contain for the purposes of a subsequent Medicare claim.

Note the rules for pathologist-determined services are slightly different. Please refer to the Act and/or the Regulations (use link and go to "latest version" if required) for further details.

5 PERSONAL PERFORMANCE – MBS EXCERPTS

5.1 Professional services attracting Medicare benefits

The following medical services will attract benefits only if they have been personally performed by a medical practitioner on not more than one patient on the one occasion (i.e. two or more patients cannot be attended simultaneously, although patients may be seen consecutively), unless a group session is involved (i.e. items 170 – 172). The requirement of "personal performance" is met whether or not essential assistance is provided, according to accepted medical practice: This includes:

- all Category 1 – Professional Attendance items except:
    - 170-172, 342-346, 820-880, 6029-6042 and 6064-6075;
- all GroupT1(Miscellaneous Therapeutic) items except:
    - 13020, 13025, 13200-13206, 13212-13221, 13703, 13706, 13750-13760, 13950, 14050, 14218, 14221 and 14245
- all Group T4 (Obstetric) items except:
    - 16400 and 16514
- all Group T3, T6, T7, T8, T9 and T10 items
- certain item numbers in Group D1 – Miscellaneous Diagnostic (refer to the MBS).
- Item 15600 in Group T2 (Radiation Oncology)

For the group psychotherapy and family group therapy services covered by Items 170, 171, 172, 342, 344 and 346, benefits are payable only if the services have been conducted personally by the medical practitioner.

Medicare benefits are not payable for these group items or any of the items listed above when the service is rendered by a medical practitioner employed by the proprietor of a hospital (not being a private hospital), except where the practitioner is exercising their right of private practice, or is performing a medical service outside the hospital. For example, benefits are not paid when a hospital intern or registrar performs a service at the request of a staff specialist or visiting medical officer.

Professional referred consultation services may only attract Medicare benefits if the service is personally performed by the medical practitioner. For more information on referred consultation services please go to the DOH's webpage – Medicare Billing in Public Hospitals.

5.2 Substantiating personal performance in a public hospital

The DOH website provides information and examples of how a consultant physician/ specialist can substantiate personal performance. Examples of how to do so can be found here. Alternatively a clinician can access all the guidelines for substantiating services provided on the DOH website under *"Health Professional Guidelines".*

5.3 Professional services not requiring personal performance

Some medical services can attract a benefit when not personally performed by a medical practitioner. This includes services where:

- part of the service is performed by a technician employed by or in accordance with accepted medical practice, acting under the supervision of the medical practitioner;
- a person other than a medical practitioner, who is employed by the medical practitioner, or in accordance with accepted medical practice, acts under the supervision of a medical practitioner.

Although the supervision requirements will vary according to the service in question, Medicare will be satisfied where the medical practitioner has:

- established consistent quality assurance procedures for the data acquisition and
- personally analysed the data and written the report.

In order to attract a benefit, the service rendered must be billed in the name of the medical practitioner and the practitioner must take full responsibility for the service. Refer to the MBS General Note *Services rendered on behalf of medical practitioners* for more information.

Supervision from outside Australia is not acceptable.

6 AFTERCARE (POST-OPERATIVE TREATMENT) – MBS EXCERPTS

Aftercare is deemed to include all post-operative treatment rendered by medical specialists and consultant physicians, and includes all attendances until recovery from the operation, the final check or examination, regardless of whether the attendances are at the hospital, private rooms or the patient's home. Aftercare need not necessarily be limited to treatment given by the surgeon or treatment given by any one medical practitioner.

The medical practitioner determines each individual aftercare period depending on the needs of the patient as the amount and duration of aftercare following an operation may vary between patients for the same operation, as well as between different operations.

6.1 Public Patients

All care directly related to a public inpatient's care must be provided free of charge. Where a patient has received inpatient treatment in a hospital as a public patient, routine and non-routine aftercare directly related to that episode of admitted care will be provided free of charge as part of the public hospital service.

Where a public patient independently chooses to consult a private medical practitioner for aftercare, then the clinically relevant service provided during this professional attendance will attract Medicare benefits.

6.2 Private Patients

Medicare will not normally pay for any consultations during an aftercare period as the Schedule fee for most operations, procedures, fractures and dislocations listed in the MBS item includes a component of aftercare.

There are some instances where the aftercare component has been excluded from the MBS item and this is clearly indicated in the item description.

If a service is provided during the aftercare phase for a condition not related to the operation, then this can be claimed, provided the account identifies the service as "Not normal aftercare", with a brief explanation of the reason for the additional services.

If a patient was admitted as a private patient in a public hospital, then unless the MBS item does not include aftercare, no Medicare benefits are payable for aftercare.

Medical practitioners should familiarise themselves with the MBS note.

7 LOCUM TENENS ARRANGEMENTS – MBS EXCERPTS

A locum in private practice is a health professional who temporarily fulfils the duties of another with the consent of the principal.

Where a non-specialist medical practitioner acts as a locum-tenens for a consultant physician or specialist, or where a specialist acts as a locum-tenens for a consultant physician, a Medicare benefit is only payable at the level appropriate for the particular locum-tenens, e.g. specialist level for a referred service rendered by a specialist locum tenens.

Medicare benefits are not payable where a practitioner is not eligible to provide services attracting Medicare benefits acts as a locum-tenens for any practitioner who is eligible to provide services attracting Medicare benefits.

Fresh referrals are not required for locum-tenens acting according to accepted medical practice for the principal of a practice i.e. referrals to the latter are accepted as applying to the former and benefit is not payable at the initial attendance rate for an attendance by a locum-tenens if the principal has already performed an initial attendance in respect of the particular instrument of referral.

Where locum-tenens arrangements are not in place a new referral must be provided and recorded in the hospital record for each patient (including date and signature of referring practitioner) for a Medicare benefit to be payable at the referred rate. If the patient does not wish to be seen as a private patient where no locum tenens arrangement exists, the patient will be treated as a public (no charge) patient.

7.1 Industrial arrangements for locums

Approved industrial RoPP arrangements remain the same for locums. If employed as a staff specialist, they must choose a RoPP scheme level (1-5). If they choose a level 2-5, the staff specialist is entitled to drawing rights. VMOs are entitled to retain their private practice revenue subject to any licensing agreement.

8 DOCUMENTATION – MBS EXCERPTS

All practitioners who provide or initiate a service where a Medicare benefit is payable must maintain *adequate* and *contemporaneous* records.

To be *adequate* the patient record needs to clearly identify the name of the patient and contain a separate entry for each attendance by the patient for a service and the date on which the service was rendered or initiated.

- Each entry must provide clinical information adequate to explain the type of service rendered or initiated.
- Each entry needs to be sufficiently comprehensible that another practitioner, relying on the record, can effectively undertake the patient's ongoing care.

To be *contemporaneous,* the patient or clinical record should be completed at the time that the service was rendered or initiated or as soon as practicable afterwards.

The name/signature of the medical practitioner performing the service must be included in the documentation.

Under Medicare, each billing practitioner must ensure that the requirements as specified in the item descriptor have been met and that the services provided are eligible for Medicare benefits to be paid.

9 PATIENT CHOICE

9.1 All Patients

Every eligible person has the right to choose to be a public or a private patient in a public hospital outpatient department based on informed financial consent. A patient can choose to be a public patient regardless of the type of referral. Conversely, if a patient wishes to be a private patient they can request a named referral from their referring practitioner.

9.2 Public Patients

Medicare eligible public patients are treated free of charge in public hospital outpatient settings except where there is a third party payment arrangement with the hospital or the State. Public patient outpatient services cannot be billed to Medicare or to the patient. Public patients will be treated by a medical practitioner nominated by the hospital.

Where a patient chooses to be treated as a public outpatient at the commencement of the outpatient service event it will apply to all subsequent medical services provided within the outpatient service event (which include pathology and diagnostic imaging).

The exception to this is when patients are seen at a site that has been granted an s19(2) exemption. Under this exemption, medical practitioners can claim against the MBS for non-admitted, non-referred professional services provided in emergency departments and outpatient clinic settings subject to satisfying the relevant conditions of the exemption as outlined in the NSW Health Guideline, *Improving Access to Primary Care in Rural and Remote Areas (s19(2)) Exemptions Initiative* (GL2017_005).

9.3 Private Patients

A patient may choose to be treated as a private patient prior to the commencement of the outpatient appointment. The patient may also elect to be seen by a medical practitioner other than the one named on the referral provided the medical practitioner is within the same speciality and has the same qualifications. This choice must occur before the commencement of a single course of treatment. A patient's choice to be seen in a private capacity including the change in medical practitioners must be confirmed in writing.

9.4 Informed Financial Consent

The NHRA requires that all patients make an election decision based on informed financial consent. A private patient must be made aware of their financial obligations when making this election. Most private outpatient services provided in NSW public hospitals are bulk billed to Medicare. This means that a patient who is eligible for a Medicare benefit assigns their right to the benefit to the servicing provider as full payment

for that service. In some cases, the medical practitioner may choose not to bulk bill. In these cases, the medical practitioner will raise a charge for the full Medicare schedule fee, and the patient will claim a benefit from Medicare, resulting in an out of pocket expense. Foreseeable out of pocket expenses are to be disclosed to the patient before the patient chooses to be private.

Patients must be made aware of any financial obligations associated with their initial, and all subsequent private (where available) medical services. When choosing to be seen as a private outpatient, clinics must advise patients that future out of pocket expenses may arise for subsequent medical services provided. This includes the requirement to obtain informed financial consent for any procedure that is an outcome of a professional attendance.

10 RESOURCES

Services Australia:

Medicare Online for health professionals – Medicare provider numbers

https://www.servicesaustralia.gov.au/organisations/health-professionals/services/medicare/medicare-benefits-health-professionals/apply-medicare-provider-number/applying-medicare-provider-number

Medicare Online for health professionals – Medicare Benefits for health professionals

https://www.servicesaustralia.gov.au/organisations/health-professionals/services/medicare/medicare-benefits-health-professionals

Medicare Online for health professionals – assignment of benefit documents

https://www.servicesaustralia.gov.au/organisations/health-professionals/services/medicare/medicare-online-health-professionals

Medicare Online for health professionals – bulk bill payments - Signature by a third party

https://www.servicesaustralia.gov.au/organisations/health-professionals/subjects/bulk-bill-payments-health-professionals

Medicare Benefits Schedule:

MBS Online

http://www9.health.gov.au/mbs/search.cfm

Department of Health:

AskMBS Advisory

https://www1.health.gov.au/internet/main/publishing.nsf/Content/AskMBS-Email-Advice-Service

Medicare Billing in Public Hospitals

https://www1.health.gov.au/internet/main/publishing.nsf/Content/ph-compliance-billing-medicare#1.1

Health Professional Guidelines

https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-professional-guidelines

s19(2) Exemptions Initiative

https://www1.health.gov.au/internet/main/publishing.nsf/Content/COAG%20s19(2)%20Exemptions%20Initiative

National Health Reform Agreement 2011

NHRA and Addendum 2020-2025

NSW Ministry of Health:

Policy Distribution System

https://www1.health.nsw.gov.au/pds/Pages/pdslanding.aspx

Staff Specialists Determination 2015 and other Industrial Instruments

https://www.health.nsw.gov.au/careers/conditions/Pages/default.aspx

Legislation and Legislative instruments

Health Insurance Act 1973*

Health Insurance Regulations 2018*

Health Insurance (General Medical Services Table) Regulations (No.2) 2020*

Health Insurance (Diagnostic Services Table) Regulations (No.2) 2020*

Health Insurance (Pathology Services Table) Regulations 2020*

*Or the “in force” version